Commonwealth of Massachusetts
Executive Office of Health and Human Services
837D Companion Guide
Effective June 23, 2005

MassHealth Companion Guide

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1.0 Introduction

1.1 What Is HIPAA?

The Health Insurance Portability and Accountability Act–Administrative Simplification (HIPAA-AS)--requires that MassHealth, and all other health insurance payers in the United States, comply with the electronic data interchange standards for health-care as established by the Secretary of Health and Human Services (HHS). HHS has adopted an Implementation Guide for each standard transaction. Version 004010X097A1 of the 837 Dental transaction is the standard established by HHS for dental claims submission.

1.2 Purpose of the Implementation Guide

The Implementation Guide for the 837 Dental claim transaction specifies in detail the required formats for claims submitted electronically to an insurance company, health-care payer, or government agency. The Implementation Guide contains requirements for use of specific segments and specific data elements within the segments, and was written for all health-care providers and other submitters. It is critical that your software vendor or IT staff review this document carefully and follow its requirements to submit HIPAA-compliant files to MassHealth.

1.3 How to Obtain Copies of the Implementation Guides

The implementation guides for X12N 837 Version 4010A1 and all other HIPAA standard transactions are available electronically at www.wpc-edi.com/HIPAA.

1.4 Purpose of This Companion Guide

This Companion Guide was created for MassHealth Trading Partners by MassHealth to supplement the 837 Dental (837D) Implementation Guide. It contains MassHealth's specific instructions for the following:

- data content, codes, business rules, and characteristics of the 837D transaction
- technical requirements and transmission options
- information on testing procedures that each Trading Partner must complete prior to submitting 837D transactions

The information in this guide supersedes all previous communications from MassHealth about this electronic transaction. The following policies are in addition to those outlined in the provider manuals for individual claim types. These policies in no way supersede MassHealth's regulations and this Companion Guide should be used in conjunction with the information found in the MassHealth Provider Manual.

1.5 Intended Audience

The intended audience for this document is the technical staff responsible for submitting electronic 837D claims to MassHealth. In addition, this information should be shared with the provider's billing office to ensure all required billing information is available for claim submission.

2.0 Establishing Connectivity with MassHealth

MassHealth is currently assessing network options for Trading Partners to transmit electronic transactions to MassHealth. An External Trading Partner Network (ETPN) will be established for use by all MassHealth Trading Partners. Until such a network is established, MassHealth Trading Partners should coordinate the transmission of 837D claims with MassHealth Customer Service at 1-800-841-2900 at 1-800-8412900. *The information provided herein will be revised as the ETPN is implemented.*

2.1 Setup

All MassHealth Trading Partners must sign a Trading Partner Agreement (TPA) and will be requested to complete a Trading Partner Profile (TPP) form prior to submitting electronic 837 transactions. Note that TPP information may be given over the telephone in lieu of completing a paper form. If you have already completed these forms, you do not have to complete them again. Please contact MassHealth Customer Service at 1-800-841-2900 (see Section 2.5: Support Contact Information) if you have any questions about these forms.

MassHealth trading partners should submit HIPAA 837D claims to MassHealth via the transactions web site, or if necessary on diskette. Trading partners must contact MassHealth Customer Service at 1-800-841-2900 with questions about these options.

After establishing a transmission method, each Trading Partner must successfully complete Trading Partner testing. Information on this phase is provided in the next section of this Companion Guide (see Section 2.2: Trading Partner Testing). After successful completion of testing, 837D transactions may be submitted for production.

All diskettes (testing and production claims) must prominently display the file name on the diskette label, following the appropriate file-naming convention listed under MassHealth Specific Data Requirements in Section 3.5 of this Companion Guide. The external label on the diskette must appear as follows:

Header:	*MassHealth Submission*
File Name:	*As determined by the submitter following the appropriate file-naming convention for test or production claims*
Transaction Type:	*Dental*
MassHealth Submitter/ Pay-to-Provider Number	*The MassHealth number of the provider or billing intermediary submitting the diskette*
Submitter Name	*The name of the provider or billing intermediary submitting the diskette*
Submission Date:	*MM/DD/YY*

Previous proprietary requirements for electronic media claims (EMCs), such as recap summary sheets and questionnaires, are not required for 837 transactions. Trading Partners submitting 837D transactions are also not required to complete an Electronic Billing Submission Agreement and Certification Statement.

2.2 Trading Partner Testing

Before submitting live 837 claims to MassHealth, each Trading Partner must be tested. All Trading Partners who plan to submit 837D transactions must contact MassHealth Customer Service at 1-800-841-2900 in advance to discuss the testing process, criteria, and schedule. Trading Partner Testing includes HIPAA compliance testing as well as validating the use of conditional, optional, and mutually defined components of the transaction.

If you are a current EMC (proprietary claims) submitter:

- We recommend where possible sending parallel 837D and EMC test files: The same data in both a proprietary and 837 format that are submitted at the same time. Trading Partners should contact MassHealth Customer Service at 1-800-841-2900 to coordinate the submission of parallel files.
- An 837 test should represent a sample of typical claims. The test file will not be adjudicated and is not required to mirror a production file, although using production files may be most convenient for submitters.
- File sizes should be close to average for the range of files typically submitted.

If you are a current paper submitter or first-time submitter:

- We require a file with a minimum of 10 and a maximum of 50 test claims.
- The member and provider data must be valid for a mutually agreed upon effective date.

The following conditions must be addressed in one or more test files:

The test files should contain as many types of claims as necessary to cover each of your business scenarios.

- original claims
- void claims (if you plan to submit void transactions)
- replacement claims (if you plan to submit void transactions and replacement claims)
- coordination of benefits claims (COB, if you plan to submit COB claims)

Providers submitting test files containing COB claims should include a minimum of 10 and a maximum of 50 COB claims with the following criteria:

- claims with commercial insurance (denied/paid)
- claims with Medicare (denied/paid)
- claims with multiple insurance, if applicable
- claims with COB overrides, if applicable to the submitter (certain provider types only as described in provider bulletins)

Providers are advised to submit the 835 remittance advice and/or the paper explanation of benefits (EOB) from the other insurer to be used in the testing process for verification of data in the COB loops. Providers must indicate which claims on the 835 remittance advice and/or paper EOB correspond to the claims on the test file.

All test files, regardless of the type of services provided, should be submitted using the following naming convention for all media types:

- **T**YYYYYYY.ZZZ, where:
  - **T** is the actual 'T' indicating Test data.
  - YYYYYYY is the seven-digit MassHealth Submitter/Pay-to-Provider number.
  - ZZZ is the sequence number assigned to the file by the Trading Partner, starting with a value of '001'.
  - This sequence number should be increased by one for each subsequent test file that is submitted. The sequence number will restart at 001 after it reaches 999.

MassHealth will process these transactions in a test environment to validate that the file structure and contents meet HIPAA standards and MassHealth-specific data requirements. Once this validation is complete, the Trading Partner may submit production 837D transactions to MassHealth for adjudication. **Test claims will not be adjudicated**.

2.3 Technical Requirements

The current maximum file size for any 837 file submitted to MassHealth is sixteen megabytes. If you are uploading multiple 837 files using the transactions web site, the maximum is sixteen megabytes per upload, not per file. If you have any questions, or would like to coordinate the processing of larger files, please contact MassHealth Customer Service at 1-800-841-2900 (see Section 2.5: Support Contact Information).

MassHealth endorses the ASC recommendation that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5,000 CLM segments. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA.

2.4 Acknowledgements

997 functional acknowledgements are generated for all 837 files submitted to MassHealth. These acknowledgements will be available for download from the transactions website. Trading Partners will also be able to request that these 997 transactions be transmitted via other existing methods of delivery of acknowledgements such as the e-mail Secure File Delivery Application (SFDA).

MassHealth uses the tilde (~) segment terminator on all outbound HIPAA-compliant transactions. HIPAA-compliant outbound transactions from MassHealth include the 835 electronic remittance advice transactions and the 997 acknowledgements.

2.5 Support Contact Information

MassHealth Customer Service at 1-800-841-2900
55 Summer Street, 6th floor
Boston, MA 02110
Phone: 1-800-841-2900
Fax:1-617-350-3489
E-mail: membersupport@mahealth.net

All diskettes containing claims must be mailed to the address above.

3.0 MassHealth-Specific Data Requirements

The following information is for production claims. For test claims refer to the Trading Partner testing section.

The following sections outline recommendations, instructions, and conditional data requirements for 837D transactions submitted to MassHealth. This information is designed to help Trading Partners construct the 837 transactions in a manner that will allow MassHealth to efficiently process claims.

Please Note:
1. Oral surgeons billing with CPT codes must use the 837 professional (837P) claim format. For information on submitting claims for oral surgery, please obtain the Implementation Guide and MassHealth Companion Guide for the X12N 837 (version 4010A) Health-care Claim: Professional.

2. Effective for dates of service January 1, 2005 and after, providers are no longer required to enter the ICD-9-CM diagnosis code in the Claim Notes on the 837D transaction (Loop 2300, NTE01 and NTE02) when providing emergency care visits to Limited members including x-rays, extractions and oral surgery services.

3.1 Claims Attachments

An electronic standard for claims attachments has not been finalized by the Centers for Medicare and Medicaid Services (CMS). Until then, MassHealth has developed an alternative method for handling electronic claims that require attachments under HIPAA. **Note: "Attachments" does not refer to Coordination of Benefits (COB) attachments such as an Explanation of Benefits (EOB). See section 3.3 for information on submitting COB claims.**

When MassHealth receives a claim requiring an attachment, it will be suspended and a Claims Attachment Form (CAF) will be mailed to the provider. The CAF will contain information relevant to the claim, including member name, MassHealth ID number, date of service, the error number and reason the attachment is being requested, and the provider name and number. The provider must return the CAF with the required attachment within 45 days of the date on the CAF to the following address:

MassHealth Customer Service
Attention: Claims
PO Box 02043-9118
Hingham, MA 02043

The claim will be held in suspense for 45 days to await receipt of the attachment. This time period will not count against the **initial** 90-day billing deadline. Failure to submit attachments with the CAF within 45 days of the date on the CAF will cause the suspended claim to deny for Edit 360 – No response to our CAF.

Until a standard for electronic attachments is finalized by CMS, providers and billing intermediaries submitting HIPAA claims to MassHealth must follow the CAF process to properly adjudicate claims requiring attachments. This does not alter the current method of claim and attachment submission via paper, which will continue to be available to providers.

3.2 Encounter and Predetermination of Benefits Claims

MassHealth will not accept either Encounter or Predetermination of Benefits Claims. For further details, see Section 3.6: Detail Data—Element Name: "Transaction Type Code".

3.3 Coordination of Benefits (COB) Claims

The implementation of the 837 transaction enables providers to submit claims for members with other health insurance electronically to MassHealth after billing all other resources. When submitting an 837 transaction to MassHealth for members with other insurance, providers must supply the other payer's adjudication details that were provided on the 835 remittance transaction. MassHealth adjudicates each service line as an individual claim. Therefore, providers are required to enter the other payer's adjudication details both at the line level and at the claim level. The adjustment reason codes entered in the COB loops should be the exact codes given by the other payer. Altering the adjudication details given by the other payer is considered fraudulent.

In addition, since the National Plan Identification Number rule has not been finalized, MassHealth requires providers to enter the MassHealth-assigned carrier code(s) on the 837 transaction to identify the other insurance. The MassHealth Recipient Eligibility Verification System (REVS) will provide a five-digit insurance carrier code(s) for all applicable insurance coverage for a member. These codes can also be found in Appendix C of your provider manual, which lists the carrier codes and the insurance company names and addresses. After billing all resources prior to billing MassHealth, enter the first three digits of the other payer(s) carrier code(s) on the 837 transaction. To ensure accurate processing, the three-digit carrier codes entered on the 837 transaction must match the first three digits of the carrier code provided by REVS (see Section 3.7: Detail Data for COB Claims).

Void Transactions

Please Note: Under HIPAA guidelines, adjustments to paid claims should be submitted as a void/replace transaction.

Void transactions are used by submitters to correct any one of the following situations:

- duplicate claim erroneously paid
- payment to the wrong provider
- payment for the wrong member
- payment for overstated or understated services
- payment for services for which payment has been received from third-party payers

Void transactions must be submitted for one service line at a time to accommodate MassHealth processing rules. For example, if a provider wishes to void out a claim that was originally submitted with three service lines, the provider would have to submit three void transactions. Each transaction would be for one of the service lines and must include the original MassHealth-generated Transaction Control Number (TCN) for the service as the "Former TCN" with a claim frequency code equal to "8".

3.5 Production File Naming Convention

837 files transmitted to MassHealth using the transmission website may use any convenient file-naming convention; the system will rename files upon receipt and issue a tracking number for reference. 837 files transmitted to MassHealth via diskette must adhere to the following naming convention:

- **H**YYYYYYY.ZZZ, where:
  - **H** is the actual letter 'H', which indicates a HIPAA-compliant production file.
  - YYYYYYY is the seven-digit MassHealth Submitter/Pay-to-Provider number.
  - ZZZ is the sequence number assigned to the file starting with a value of '001'.
  - The sequence number should be increased by one for each subsequent file that is submitted. The sequence number will restart at 001 after it reaches 999.

3.6 Detail Data

Although submitters can view the entire set of required data elements in the 837D Implementation Guide, MassHealth recommends that submitters pay special attention to the following segments. These segments have already generated questions.

Loop	Segment		Element Name	Companion Information
----	ISA	05	Interchange Sender ID Qualifier	'ZZ'
----	ISA	06	Interchange Sender ID	Your seven-digit MassHealth submitter ID.
----	ISA	07	Interchange Receiver ID Qualifier	'ZZ'
----	ISA	08	Interchange Receiver ID	'DMA7384'
----	GS	02	Application Sender's Code	Your seven-digit MassHealth submitter ID.
----	GS	03	Application Receiver's Code	'DMA7384'
----	BHT	06	Transaction Type Code	In the Beginning of Hierarchical Structure (BHT) loop, BHT06 should always be equal to "CH" and all submitted 837 transactions should be claims for payment. A set of encounters, indicated by BHT06 equal to "RP," will pass compliance checks but no transactions within the set will be released to the adjudication system.
1000A	NM1	09	Submitter Name	Your seven-digit MassHealth submitter ID.
1000B	NM1	09	Receiver Name	'DMA7384'
2000B	SBR	09	Subscriber Information Claim Filing Indicator Code	'MC'
2010AA	REF	02	Billing Provider Secondary Identification Number/Reference Identification	Seven-digit MassHealth provider number when REF01 is '1D' and REF02 is the seven-digit MassHealth number of the entity doing the billing. For example, a billing agency number, a provider group number, or an individual provider.
2010AB	REF	02	Pay-to Provider Secondary Identification Number/Reference Identification	Seven-digit MassHealth provider number when REF01 is '1D' and REF02 is the seven-digit MassHealth provider number identifying the group or individual provider receiving the payment. If this segment is not submitted, the billing provider number from the 2010AA segment is used as the pay-to-provider number.
2010BA	NM1	09	Subscriber Name/Identification Code	10- or 12-character MassHealth member's recipient identification number (RID) when NM108 is 'MI' and NM102 is '1.'
2300	CLM	19	Predetermination of Benefits Code	MassHealth does not support Predetermination of Benefits. Do not use.
2300	REF	02	Referral Identification/Reference Identification	If prior authorization exists, place 'G1' in REF01 and the MassHealth-assigned six-digit prior-authorization number in REF02. **Note:** Multiple PAs should not be

Loop	Segment		Element Name	Companion Information
				entered in the 2300 loop at the claim level. Multiple PAs on a claim may be billed in one of two ways. A PA that applies to a majority of the services being billed may be entered in the 2300 loop at the claim line level, with any additional PAs billed in the appropriate 2400 loop service line level. Alternatively, PAs may be entered in the appropriate 2400 loop service line level only, with no entry in the 2300 loop claim level.
2300	REF	02	Original Reference Number/Reference Identification	If submitting a void/replace claim, enter 'F8' in REF01 and the former transaction control number (TCN) in REF02.
2300	PWK	01	Report Type Code	No entry required.
2300	PWK	02	Report Transmission Code	No entry required.
2310B	REF	02	Rendering Provider Secondary Identification Number/Reference Identification	Seven-digit MassHealth provider number when REF01 is '1D' and REF02 is the seven-digit MassHealth provider number of the servicing provider. If this provider number is not submitted, the pay-to provider number is used as the claim-level servicing provider number.
2400	REF	02	Referral Number/Reference Identification	Enter 'G1' in REF01 and the six-digit prior authorization number in REF02 if the service being billed on this line requires prior authorization and the prior authorization number is **different from or was not already entered** in the 2300 Loop (also see 2300 REF01/REF02 Prior Authorization or Referral Number Identification).
2420A	REF	02	Rendering Provider Secondary Identification Number/Reference Identification	Seven-digit MassHealth provider number when REF01 is '1D' (only if different from 2310B) and REF02 is the seven-digit MassHealth provider number of the servicing provider. Use this segment only if this number is different from claim-level (2310B) servicing provider number.

3.7 Detail Data for COB Claims

Loop	Segment		Element Name	Companion Information
2330B	NM1	08	Identification Code Qualifier	Enter value 'PI' for payer identification.
2330B	NM1	09	Other Payer Primary Identifier	MassHealth-assigned three-digit carrier code when NM108 is 'PI' (see Appendix C: Third Party Liability Codes in your provider manual or refer to: mass.gov/MassHealth Provider Library for information).

Loop	Segment	Segment Name	Companion Information
2430	SVD	Service Line Adjudication Information	Required if other payer has adjudicated the service line.
2430	CAS	Service Line Adjustment	Required if other payer has not paid in full. All adjustment reason codes given by the other payer must be present.

3.8 Additional Information

MassHealth does not process certain loops that do not apply to the MassHealth business model. For example, MassHealth does not process *2000C Patient Hierarchical Level* since there is no dependent coverage (all members are subscribers). In certain circumstances, these loops may required be in a compliant 837 transaction. However, the data content of these loops will not affect the MassHealth claims adjudication process.

3.9 Service Codes

Please consult Subchapter 6 of your MassHealth provider manual for information on acceptable service codes or consult MassHealth's Web site at: http://www.mass.gov/masshealth.

3.10 Support Contact Information

MassHealth Customer Service at 1-800-841-2900
55 Summer Street, 6th floor
Boston, MA 02110
Phone: 1-800-841-2900
Fax:1-617-350-3489
E-mail: membersupport@mahealth.net

All diskettes containing claims must be mailed to the address above.

4.0 Sample MassHealth 837D Transactions

4.1 MassHealth 837D Transaction

ISA*00* *00* **ZZ*9902813 *ZZ*DMA7384
*030220*0713*U*00401*990305113*0*P*:~
GS*HC*9902813*DMA7384*20030220*0713*990305113*X*004010X097~
ST*837*990305113~
BHT*0019*00*990305113*20030220*0713*CH~
REF*87*004010X097D~
NM1*41*2*CLAIMS PROCESSING SERVICE INC*****46*9902813~
PER*IC*JOHN SMITH JR*TE*8882557293~
NM1*40*2*MA MED*****46*DMA7384~
HL*1**20*1~
NM1*85*2*CLEARINGHOUSE-BILLING AGENT*****24*010723290~
N3*1234 MAIN STREET~
N4*N DARTMOUTH*MA*027470000~
REF*1D*9902813~
NM1*87*2*PROVIDER ENTITY*****24*010723290~
N3*654 ELM STREET~
N4*N DARTMOUTH*MA*027470000~
REF*1D*9722530~
HL*2*1*22*0~
SBR*P*18****6***MC~
NM1*IL*1*AMARAL*MARIA****MI*0123456789~
N3*76 UNION AVE~
N4*NEW BEDFORD*MA*027400000~
DMG*D8*19470812*F~
NM1*PR*2*MASSHEALTH*****PI*DMA7384~
CLM*8285049*53.00***11::1*Y*C*N*Y~
DTP*472*D8*20030214~
NM1*82*1*PROVIDER*ENTITY****34*010723290~
PRV*PE*ZZ*122300000N~
REF*1D*0281654~
LX*1~
SV3*AD:D0220*12.00****1~
LX*2~
SV3*AD:D9110*41.00****1~
TOO*JP*9~
NM1*82*1*PROVIDER*ENTITY****34*123456789~
PRV*PE*ZZ*122300000N~
REF*1D*0123456~
SE*36*990305113~
GE*1*990305113~
IEA*1*990305113~

4.2 MassHealth 837D COB Transaction

ISA*00* *00* *ZZ*9902813 *ZZ*DMA7384
*030220*0713*U*00401*990305113*0*P*:~
GS*HC*9902813*DMA7384*20030320*0713*990305113*X*004010X097~
ST*837*990305113~
BHT*0019*00*990305113*20030220*0713*CH~
REF*87*004010X097D~
NM1*41*1*KECY*KEVIN*T***46*9012345918341~
PER*IC*KEVIN KECY*ED*6175551212*TE*6175555555*EM*KKECY@NT.DMA.STATE.MA.US~
NM1*40*2*MA MED*****46*9999999~
HL*1**20*1~
NM1*85*2*YERUVA*****24*04-3587960~
N3*PO BOX 123*157 WEST 57TH STREET~
N4*BOSTON*MA*02101*US~
REF*1D*0250913~
NM1*87*2*GROUP NAME*****24*04-0000000~
N3*123 SUMMER STREET~
N4*BOSTON*MA*012110000~
REF*1D*0250953~
HL*2*1*22*0~
SBR*P*18*500*MAGGIE JONES**1***09~
NM1*IL*1*JOHNSON*TIM****MI*0117626543~
N3*123 WINTER STREET~
N4*BOSTON*MA*012110000~
DMG*D8*19880501*F~
NM1*PR*2*SMITH*****PI*9012345912345~
CLM*1.1.120.28*70.00***11::1*Y**Y*N~
REF*G1*P98999~
SBR*P*19*28199*MED S UNION*****CI~
DMG*D8*19630606*F~
OI***Y***Y~
NM1*IL*1*NIXON*JANE****MI*527471888~
NM1*PR*2*payer name*****PI*083~
LX*1~
SV3*AD:D1120*70.00***I*1~
DTP*472*D8*20030108~
SVD*083*30.00*AD:D1120**1~
CAS*PR*1*10.00~
DTP*573*D8*20030118~
SE*36*990305113~
GE*1*990305113~
IEA*1*990305113~

5.0 Version Table

Version	Date	Section/Pages	Description
1.0	01/31/03		Draft Document Created
1.1	03/10/03		Draft Document Revised
1.2	04/29/03		Final Revision
1.3	04/30/03		Production Version Issued
1.4	9/11/03	Entire Document	Production Version Issued
1.5	11/24/03	Links/text updated throughout document	Production Version Issued
1.6	05/18/04	PA revisions added to table in section 3.6, Revision to section 2.4	Production version issued
1.7	12/09/04	Update to Section 2.4 to reflect new Secure File Data information	Production version issued
1.8	04/19/05	Updates made to: • Section 3.0 – New note combined at end of section on page number 6, • Detail Data table on page number 11, (removed lines 2300 NTE 01 and 2300 NTE 02)	Production version issued
1.9	05/18/05	Updates made to Sections 2.3, 2.5, 3.1, 3.7, 3.9 and 3.10 to reflect TPA and 60-day Noticing	Draft version issued. Production issue to follow.

Appendix A: Frequently Asked Questions

Q. How can I receive 997 functional acknowledgements for rejects at the claim level rather than the transaction-set level?

A. The 997 acknowledges rejection of all claims within the ST/SE boundary. The only way to receive a 997 rejection for each invalid claim is to submit your 837 with only one claim per transaction set.

Q. Massachusetts has allowed dentists who specialize in oral surgery to enroll and bill for dental procedures using the CDT codes and the CPT codes for oral surgery services. The 837D Implementation Guide states that CDT codes are the only service codes allowed when filing an electronic claim. What is the process to submit claims for oral surgery services using a CPT code?

A. Submit oral surgery claims with CPT codes using the 837P claim format.

Q. Should I use the place-of-service codes contained in the HIPAA Implementation Guide when submitting MassHealth paper claim forms too?

A. No, when submitting paper MassHealth claim forms use the appropriate place of service code found in Subchapter 5 of your MassHealth provider manual.

Q. If I identify other insurance that is not on file with MassHealth, how do I submit the claim?

A. Follow the same process as you would for any coordination of benefits (COB) claim. To obtain the MassHealth-assigned carrier code, cross-reference the insurance name with the appropriate carrier code in Appendix C of your provider manual, and enter the first three digits of the code on your 837 transaction. Concurrently you should request that the MassHealth file be updated by sending all pertinent information to the appropriate address below.

MassHealth or
Third-Party Liability Unit
P.O. Box 9209
Boston, MA 02209
Fax: 617-357-7604

MassHealth
Medicare Unit
600 Washington Street
Boston, MA 02111

Do not send claim forms to these addresses.

Appendix B: Provider Transaction Table

If you currently submit MassHealth invoice type	…and you are this provider type	…and you are billing this covered code[1]	…then use this HIPAA transaction
11	Dentist	ADA [2]	837D
11	Dentist	CPT	837P
11	Dental Clinic	ADA [2]	837D
11	Dental Clinic	CPT	837P
11	Undergraduate Dental School Clinic	ADA [2]	837D
11	Graduate Dental School Clinic	ADA [2]	837D
11	Graduate Dental School Clinic	CPT	837P
11	Dental Lab	ADA [2]	837D
11	Community Health Center	ADA [2]	837D
11	Community Health Center	CPT	837P
11	Outpatient Hospital or Hospital Licensed Health Center	ADA [2]	837D
11	Outpatient Hospital or Hospital Licensed Health Center	CPT	837P
11	Group Practice Organization	ADA [2]	837D
11	Group Practice Organization	CPT	837P

[1] Please consult the most recent Subchapter 6 and Appendix E of your provider manual for information on acceptable service codes or consult MassHealth's Web site at: www.mass.gov/masshealth.

[2] Please note that ADA (American Dental Association) codes are also referred to as CDT (Current Dental Terminology) codes.

Appendix C: Links to On-line HIPAA Resources

The following is a list of on-line resources that may be helpful.

Accredited Standards Committee (ASC X12)

- ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. www.x12.org

American Dental Association (ADA)

- This site is a resource for the Dental Terminology 4th Edition codes (CDT-4, HCPCS Level II "D" codes), and for the Dental Content Committee that sets standards for the dental claim form and maintains dental codes. www.ada.org

American Hospital Association Central Office on ICD-9-CM (AHA)

- This site is a resource for the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes, used in medical transcription and billing, and for Level I HCPCS. www.ahacentraloffice.org

American Medical Association (AMA)

- This site is a resource for the Current Procedural Terminology 4th Edition codes (CPT-4). The AMA copyrights the CPT codes. www.ama-assn.org

Association for Electronic Health-care Transactions (AFEHCT)

- A health-care association dedicated to promoting the interchange of electronic health-care information. www.afehct.org

Centers for Medicare and Medicaid Services (CMS)

- CMS, formerly known as HCFA, is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Health-care Transactions and Code Sets Model Compliance Plan at www.cms.gov/hipaa/hipaa2/
- This site is the resource for information related to the Healthcare Common Procedure Coding System (HCPCS). www.cms.hhs.gov/medicare/hcpcs
- This site is the resource for Medicaid HIPAA information about the Administrative Simplification provision. www.cms.gov/medicaid/hipaa/adminsim

Designated Standard Maintenance Organizations (DSMO)

- This site is a resource for information about the standard-setting organizations, and transaction change request system. www.hipaa-dsmo.org

Health Level Seven (HL7)

- HL7 is one of several ANSI-accredited Standards Development Organizations (SDO), and is responsible for clinical and administrative data standards. www.hl7.org

MassHealth

- This site assists providers with MassHealth billing and policy questions as well as provider enrollment at: mass.gov/masshealth.

Medicaid HIPAA Compliance Concept Model (MHCCM)

- This site presents the Medicaid HIPAA Compliance Concept Model, information, and a toolkit. www.mhccm.org

National Council of Prescription Drug Programs (NCPDP)

- The NCPDP is the standards and codes development organization for pharmacy. www.ncpdp.org

National Uniform Billing Committee (NUBC)

- NUBC is affiliated with the American Hospital Association, and develops standards for institutional claims. www.nubc.org

National Uniform Claim Committee (NUCC)

- NUCC is affiliated with the American Medical Association. It develops and maintains a standardized data set for use by the non-institutional health-care organizations to transmit claims and encounter information. NUCC maintains the national provider taxonomy. www.nucc.org

Office for Civil Rights (OCR)

- OCR is the office within the U.S. Department of Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa

United States Department of Health and Human Services (DHHS)

- This site is a resource for the Notice of Proposed Rule Making, rules, and other information about HIPAA. www.aspe.hhs.gov/admnsimp

Washington Publishing Company (WPC)

- WPC is a resource for HIPAA-required transaction implementation guides and code sets. www.wpc-edi.com/HIPAA

Workgroup for Electronic Data Interchange (WEDI)

- A workgroup dedicated to improving Health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA. www.wedi.org